SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*43174*
Company Tracking Number:	*LFF06363 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LNL_Reinstatement or Change Application*		
Project Name/Number:	*LNL_Reinstatement or Change Application/LFF06363 et al*		

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: LNL_Reinstatement or Change Application	SERFF Tr Num: JEPL-126252962	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43174
Sub-TOI: L08.000 Life - Other	Co Tr Num: LFF06363 ET AL	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Jane Neidermyer, William Otten, Jeanine Taylor	Disposition Date: 08/11/2009
	Date Submitted: 08/10/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: LNL_Reinstatement or Change Application
Project Number: LFF06363 et al
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/11/2009

Deemer Date:
Submitted By: Jane Neidermyer
Filing Description:
Re: Individual Life Application Forms
LFF06363 Reinstatement or Change Application
LFF07197 Continuation of Details Supplement
The Lincoln National Life Insurance Company
Group & NAIC #: 020-65676

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/11/2009
Created By: Jeanine Taylor
Corresponding Filing Tracking Number:

We are submitting the above-referenced forms for your review and approval. These are new forms and will not be

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*43174*
Company Tracking Number:	*LFF06363 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LNL_Reinstatement or Change Application*		
Project Name/Number:	*LNL_Reinstatement or Change Application/LFF06363 et al*		

replacing any other forms.

Form LFF06363 Reinstatement or Change Application will be used to apply for reinstatement of a lapsed policy, or to apply for a change to a currently active policy. It will become part of the policy. Form LFF07197 is an additional sheet which may be used with LFF06363, with any previously approved application form, and with any application form approved in the future. The form allows extra space in case there is not sufficient room for a complete answer on the application form itself.

These forms are multi company forms. In the event that one of our underwriting companies referenced in the forms chooses to stop using either form, it is our intent to remove the company name from the form without re-filing the form. Upon approval, the company reserves the right to change the format of the forms without altering the approved language. As the forms are multi company, we are submitting filings similar to this one for each of the companies listed on the forms. We have bracketed the Service Address of the companies in order to provide for flexibility. We confirm the brackets will not appear on production versions of the form.

Form LFF06363 has attained a Flesch score of 50.98 and form LFF07197 has a Flesch score of 50.39. The forms have been submitted concurrently for approval to our Home State of Indiana. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards. To the best of our knowledge and belief, these forms comply with all the applicable laws and regulations of your state. If applicable, the appropriate certifications, transmittals, checklists and filing fees are included.

Please accept this as our assurance that we are in compliance with requirements of Arkansas Code Ann. 23-79-138. We provide a document entitled “Important Information to Policyholders”, which contains the required information. Also, please accept this as our assurance that we are in compliance with the requirements of Regulation 49 and we provide the required Guaranty Association Notice.

We trust the information provided is satisfactory and look forward to your response. Should you require additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5627 or by fax at 1-603-226-5128 .

Company and Contact

Filing Contact Information

Jane Neidermyer, Senior Compliance Analyst
One Granite Place
PO Box 515
Concord, NH 03302-0515

jane.neidermyer@lfg.com
800-258-3648 [Phone] 5627 [Ext]
603-226-5128 [FAX]

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*43174*
Company Tracking Number:	*LFF06363 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LNL_Reinstatement or Change Application*		
Project Name/Number:	*LNL_Reinstatement or Change Application/LFF06363 et al*		

350 Church Street
Hartford, CT 06103
(800) 258-3648 ext. [Phone]

Group Code: 20
Group Name:
FEIN Number: 35-0472300

Company Type: Life Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$70.00
Retaliatory?	Yes
Fee Explanation:	IN fee of $35.00 for each form filed
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	$70.00	08/10/2009	29754275

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
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Product Name:	*LNL_Reinstatement or Change Application*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/11/2009	08/11/2009

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
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Disposition

Disposition Date: 08/11/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*43174*
Company Tracking Number:	*LFF06363 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
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Project Name/Number:	*LNL_Reinstatement or Change Application/LFF06363 et al*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Reinstatement/Change App		Yes
Form	Continuation of Detail		Yes

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*43174*
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Form Schedule

Lead Form Number: LFF06363 et al

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LFF06363	Application/ Enrollment Form	Reinstatement/Change App	Initial		50.980	LFF06363 Final for filing.pdf
	LFF07197	Application/ Enrollment Form	Continuation of Detail	Initial		50.390	LFF07197_Generic for filing.pdf

Lincoln Financial Group®

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☐ **First Penn-Pacific Life Insurance Company,** Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Original Insured.)

THE UNDERWRITING PROCESS (if applicable)

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT (if applicable)

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

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REINSTATEMENT OR CHANGE APPLICATION FOR LIFE INSURANCE - PART I

Original Insured A *(First, Middle, Last)*	**Policy Number**

NON-UNDERWRITTEN POLICY CHANGES *(In addition to this section; please complete questions 1-18 on page 2, questions 1-18 on page 6Ai (if applicable); and the Signatory Section.)*

A. ☐ Decrease Face/Specified Amount to:
$ _____

B. ☐ Change Premium to: $ _____
(Based on change(s) in this section.)

C. ☐ Correct Date of Birth to: *(mm/dd/yyyy)*
_____

D. ☐ Cancel Benefits or Riders: *(Please provide full details.)*
_____
_____

E. ☐ Decrease Benefits or Riders: *(Please provide full details.)*
_____

F. ☐ Change Death Benefit Option to:
☐ Level ☐ Increasing/Decrease Current Face Amount
(To maintain original face, complete full application and Underwritten Policy Changes Section.)

G. ☐ Other: _____
_____

UNDERWRITTEN POLICY CHANGES *(Based on this change, complete pages 2 - 8 of application (and Sections A & B as applicable).)*

H. ☐ Reinstatement

I. ☐ Change Death Benefit Option to Increasing/Maintain Current Face Amount

J. ☐ Increase/Add Benefits/Riders: *(please provide full details)*
_____

K. ☐ Change to Non-Tobacco Rates:_____

L. ☐ Increase Face/Specified Amount to:
$ _____

M. ☐ Rate/Premium Class Change: _____

N. ☐ Other:_____

O. ☐ Exercise Exchange of Insured/Substitute Life Rider

P. ☐ Change Premium to: $_____
(Based on change(s) in this section)

SPECIAL INSTRUCTIONS *(List details from questions above; please include question number details pertain to. If more space is required use the "Continuation of Details Supplement.")*

TERM CONVERSION / GUARANTEED INSURABILITY OPTION **Owner of Original Policy must sign page 8.**
(Please complete questions below, questions 1-48 on pages 2 and 3, and the Signatory Section. Please also complete Section A questions 1-19 and Section B as applicable.)

Q. Conversion/Option Type: *(Check one)*
- i. ☐ Child ☐ Spouse Rider ☐ Partial Policy Conversion *(Check one)*
  - ☐ Keep Balance of Policy/Rider in Force
  - ☐ Terminate Balance of Policy/Rider
- ii. ☐ Full Policy Conversion
- iii. ☐ Guaranteed Insurability Regular Option
- iv. ☐ Guaranteed Insurability Alternate Option
- v. ☐ Other: _____

R. Conversion/Option Effective Date: _____

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PART I Continued

Policy Number

APPLICANT INFORMATION - ORIGINAL INSURED A (Required Section)

1. Original Insured A *(First, Middle, Last)*		2. ☐ Male ☐ Female
3. Date of Birth (If over age 70, please complete Section B.) *(mm/dd/yy)*	4. Soc. Sec. No.	5. Are you a citizen of the United States? ☐ Y ☐ N If "No," what country?
6. Place of Birth *(State, Country)*	7. Driver's License # & State	
8. Home Address *(Street, City, State, ZIP)*		
9. Occupation/Duties	10. Employer	
11. Business Address *(Street, City, State, ZIP)*		
12. Annual Earned Income $	13. Annual Unearned Income $	14. Net Worth $
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N *(If "Yes," please complete the Financial Supplement.)*	16. Primary Phone # ☐ AM ☐ PM	17. Work Phone # ☐ AM ☐ PM
18. Email Address		

COVERAGE INFORMATION *(For New Coverage as available per product)*

(Any request for increased coverage may require underwriting. Please complete entire application.)

19. Plan of Insurance _____ 20. Amount of Insurance $ _____
(If applying for variable life insurance please complete allocation form(s).) *(Specified Amount, if UL or VUL)*

21. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term.)*
☐ Level ☐ Increase by Cash Value/Accumulated Value (as applicable)

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

22. Save Age? ☐ Y ☐ N *(If not saving age, policy will be current dated.)*

23. Additional Benefits and Riders: *(If applicable)*

☐ Accelerated Benefit Rider
☐ Supplemental Coverage $ _____
☐ Term on Spouse/Other Insured Rider $ _____
(Please complete Section B - Applicant Information - Original Insured B)
☐ Children's Term Insurance Rider *(Complete Child's Supplement)*
☐ Waiver of Premium
☐ Waiver of Monthly Deductions
☐ Waiver of Specified Premium $ _____

☐ Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentages/etc.):

PART I Continued

Policy Number

BILLING INSTRUCTIONS ***(As available per product) (For New Coverage)***

24. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT) ☐ Other _____

25. Modal Planned Premium: $ _____ 26. Lump Sum: $ _____ ☐ 1035 Exchange

27. Special Billing: *(check one, if applicable)* ☐ New List Bill ☐ Existing List Bill Number: _____

28. Source of Premium: _____ 29. Automatic Premium Loan: ☐ Y ☐ N
(inheritance, loan, business activity) *(Complete for Whole Life only.)*

30. Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
☐ Owner in Question 31 ☐ Owner in Question 37 ☐ Insured at Business ☐ Insured at Residence ☐ Other *(indicate below)*

OWNER INFORMATION ***(If left blank, Original Insured(s) will be owner) (For New Coverage)***

31. Owner Name (Trust Name, Date & Trustees)	
32. Owner Address	
33. Relationship to Original Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name (Trust Name, Date & Trustees)	
38. Owner Address	
39. Relationship to Original Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Y ☐ N

BENEFICIARY DESIGNATION (*Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.) (For New Coverage)*

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here ☐.

44. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured
45. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured
46. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured
47. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured

48. Special Instructions *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*

Policy Number

PART I Continued

APPLICANT INFORMATION - ORIGINAL INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐Y ☐N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
(Include Disability Insurance if disability reinstatement or exercise of GPI Rider.)
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐Y ☐N

Company	Amount	Type (Life or Disability)	Purpose of Insurance (Business, Personal)
	$		
	$		

52. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $_____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* ☐Y ☐N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* ☐Y ☐N

55. Are you currently receiving, or within the past 10 years have you received or applied for, any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance?
(If "Yes", provide further information in the "Details" space provided.) ☐Y ☐N

GENERAL RISK INFORMATION - ORIGINAL INSURED A

56. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member?
(If "Yes", an Aviation Supplement is required; this includes balloon pilots.) ☐Y ☐N

57. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports?
(If "Yes", an Avocation Supplement is required.) ☐Y ☐N

58. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year?
(If "Yes", a Foreign Travel or Residence Supplement is required.) ☐Y ☐N

59. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in the "Details" space provided.)* ☐Y ☐N

60. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.)* ☐Y ☐N

61. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)* ☐Y ☐N

62. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐Y ☐N

Type:	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

PART I Continued

Policy Number

MEDICAL INFORMATION - ORIGINAL INSURED A ***(Answer this section only when required.)***

63. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

64. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N
Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

65.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

66. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*

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HEALTH SUMMARY - PART I continued

Policy Number

APPLICANT INFORMATION - ORIGINAL INSURED A

► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.

	Yes	No
67. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
68. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
69. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
70. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
71. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
72. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
73. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

74. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

75. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*

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SECTION A - ADDITIONAL INSURED

Policy Number

APPLICANT INFORMATION - ORIGINAL INSURED B

1. Original Insured B *(First, Middle, Last)*		2. ☐ Male ☐ Female
3. Date of Birth (If over age 70 please complete Section B.) *(mm/dd/yy)*	4. Soc. Sec. No.	5. Are you a citizen of the United States? ☐ Y ☐ N If "No," what country?
6. Place of Birth *(State, Country)*	7. Driver's License # & State	
8. Home Address *(Street, City, State, ZIP)*		
9. Occupation/Duties	10. Employer	
11. Business Address *(Street, City, State, ZIP)*		
12. Annual Earned Income $	13. Annual Unearned Income $	14. Net Worth $
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N *(If "Yes," please complete the Financial Supplement.)*	16. Primary Phone # ☐ AM ☐ PM	17. Work Phone # ☐ AM ☐ PM
18. Email Address		

19. Beneficiary for applicable Rider: *(For New Coverage)* (Include Trust Name, Date & Trustees) a. Name	
b. Soc Sec. No./TIN	c. Relationship to Original Insured B

20. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
(If "Yes", please complete and sign all required replacement forms.)

21. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
(Include Disability Insurance if disability reinstatement or exercise of GPI Rider.)
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	

22. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐ Y ☐ N

Company	Amount	Type (Life or Disability)	Purpose of Insurance (Business, Personal)
	$		
	$		

23. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $_____

24. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* ☐ Y ☐ N

25. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* ☐ Y ☐ N

26. Are you currently receiving, or within the past 10 years have you received or applied for, any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance? *(If "Yes", provide further information in the "Details" space provided.)* ☐ Y ☐ N

Policy Number

GENERAL RISK INFORMATION - ORIGINAL INSURED B

27. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* ☐ Y ☐ N

28. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* ☐ Y ☐ N

29. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* ☐ Y ☐ N

30. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* ☐ Y ☐ N

31. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* ☐ Y ☐ N

32. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* ☐ Y ☐ N

33. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐ Y ☐ N

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

MEDICAL INFORMATION - ORIGINAL INSURED B *(Answer this section only when required.)*

34. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

35. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N

Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

36.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

37. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*

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Policy Number

HEALTH SUMMARY - SECTION A continued

APPLICANT INFORMATION - ORIGINAL INSURED B

► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.

	Yes	No
38. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
39. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
40. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
41. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
42. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
43. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
44. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

45. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

46. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*

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Policy Number

SECTION B - DEFINED AGE QUESTIONNAIRE
(Complete if either Original Insured is age 70 or over.)

1. Original Insured A *(First, Middle, Last)* _____

2. Original Insured B *(First, Middle, Last)* _____

	Original Insured A	Original Insured B
3. Will you, the original insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	☐Y ☐N	☐Y ☐N
4. Have you, the original insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	☐Y ☐N	☐Y ☐N
5. Have you, the original insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the original insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	☐Y ☐N	☐Y ☐N
6. Have you, the original insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	☐Y ☐N	☐Y ☐N
7. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*		

OWNER INFORMATION

8. Owner Name _____	Owner
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	☐Y ☐N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	☐Y ☐N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	☐Y ☐N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Application Supplement.)*	☐Y ☐N
13. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*	

Policy Number

PART I Continued

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Original Insured(s) and the Owner, if other than the Original Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐Y ☐N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐Y ☐N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐Y ☐N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐Y ☐N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. Any new, reinstated or increased coverage will not be in effect unless and until (a) all premiums and charges have been paid to and accepted by the Company; (b) the requested changes have been accepted by the Company; and (c) statements on this form and on any other application submitted as a part of this request are correct at the time of such payments and approval. Blank spaces in questions 31-43 (Owner Information) and/or 44-47 (Beneficiary Designation) of Part I of the application and question 19 of Section A of the application indicate no change from the previous designation.
2. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
3. I/WE HAVE READ, or have had read to me/us, the completed Reinstatement or Change Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
4. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
5. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
6. This application shall amend and be a part of the original application and the policy. The incontestability and suicide provisions in the policy are amended to apply to any new or increased coverage from the date the new or increased coverage is made to be in effect by the Company. Upon reinstatement, the period of contestability with respect to statements made in this application shall begin anew as of the date the new or increased coverage is made to be in effect by the Company.
7. For Universal Life and Variable Life, the effective date of any change in death benefit or any Rider requested on pages 1 and 2 shall be the Monthly Anniversary Day which coincides with or next follows the date the Company approves this application.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AR, NM and OH Only. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Policy Number

PART I Continued

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

For Non-Underwritten Changes - The Company will not obtain medical information on this authorization for Non-Underwritten Policy Changes questions A-G.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

This Application consists of: a) Part I (including Sections A-B if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which a re required by the Company for the plan, amount and benefits applied for. This Reinstatement or Change Application for Life Insurance - Part I shall be complete when it includes Applicant Information - Original Insured A, and any or none of the following (please check, as applicable, included Sections A-B):

☐ **Section A- Applicant Information -Original Insured B,**

☐ **Section B - Defined Age Questionnaire.**

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

Signature of Original Insured A (Parent or Guardian if under 14 years of age)

Signature of Original Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Original Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Original Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? ☐ Y ☐ N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Y ☐ N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Original Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative (Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

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CONTINUATION OF DETAILS SUPPLEMENT

(Please complete this page whenever there is insufficient room to provide complete details for any question in the application requiring a detailed response. Use a separate page for each insured as applicable.)

Proposed Insured Name _____ Date of Birth _____
(First) (Middle) (Last) *(mm/dd/yy)*

Details: *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

Question # Details:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I have read or have had read to me the completed Continuation of Details before signing below. All statements and answers in this supplement are correctly recorded and are full, complete and true. I agree that this Continuation of Details Supplement constitutes a part of my application for insurance. I understand that if any answers on this supplement are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

_____ _____
Signature of Proposed Insured (Parent or Guardian if under 14 years of age) **Witness**

_____
Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

SERFF Tracking Number:	*JEPL-126252962*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*43174*
Company Tracking Number:	*LFF06363 ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LNL_Reinstatement or Change Application*		
Project Name/Number:	*LNL_Reinstatement or Change Application/LFF06363 et al*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Other certifications are appropriate for the policy, not applications.

Attachment:

AR_Readability.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: This filing is for 2 application forms

Comments:

Arkansas

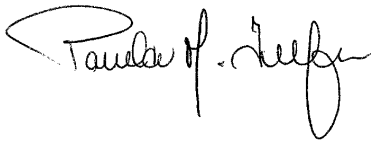
READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: ***LFF06363 – Reinstatement or Change Application for Life Insurance***
LFF07197 – Continuation of Details Supplement

We hereby certify that the attached Form(s) is (are) in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has (have) achieved a Flesch Reading Ease score of:

Form Number:	***Flesch:***
LFF06363	***50.98***
LFF07197	***50.39***



Pamela M. Telfer, Assistant Vice President
Product Compliance

Date: August 6, 2009